martha e. stewart, md, llc
dermatology

# INFORMED CONSENT FOR TELEMEDICINE SERVICES

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Dr. Martha Stewart or Dr. Olivia Gioe providing health care services to me via telemedicine.

The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

I understand that I will be responsible for any copayments, coinsurances, or deductibles that apply to my telemedicine visit. **If my insurance company denies my bill, I understand that I will be financially responsible for a $59 charge.**

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Martha E. Stewart, MD, LLC Dermatology at 985-727-7701. As long as this consent is in force (has not been revoked), Dr. Martha Stewart or Dr. Olivia Gioe may provide health care services to me via telemedicine without the need for me to sign another consent.

**By signing this form, I understand the following:**

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and I may receive copies of this information for a reasonable fee.

3. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. These alternatives have been explained to my satisfaction.

4. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

5. I understand that in rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision-making by the physician.

6. I understand that in very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

7. I understand that in rare cases, a lack of access to complete medical records may result in adverse drug interaction or allergic reactions or other judgment errors.

8. I understand that if FaceTime is used for my telemedicine visit, there are potential security/privacy risks.

**Waiver/Release:** By signing below, I understand and agree that I solely assume the risk of any errors or deficiencies in the electronic transmission of information during my telehealth visit or in the electronic submission of my images to my dermatologist and further understand that no warranty or guarantee has been made to me concerning any particular result related to my condition or diagnosis. To the extent permitted by law, I also agree to waive and release my dermatologist and Martha E. Stewart, MD, LLC from any claims I may have about this advice or the telehealth visit generally. The consent provided in this document will expire in one year from the date I sign it, but my waiver and release shall apply indefinitely for any telehealth visits that occur during the one-year period after my signature date.

## Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Dr. Martha Stewart or Dr. Olivia Gioe to use telemedicine in the course of my diagnosis and treatment.

Patient Name (please print): _____ DOB: _____

Signature of Patient (or person
Authorized to sign for patient): _____ Date: _____

If authorized signer, relationship to patient: _____

Witness: _____ Date: _____

I have been offered a copy of this consent form (patient's initials) _____